		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0001636

Facility Name: Champaign County Nursing Home

Address: 1701 East Main St. (Number) Urbana (City) 61802-2836 (Zip Code)

County: Champaign

Telephone Number: (217) 384-3784 **Fax #** (217) 337-0120

IDPA ID Number: 366006910001

Date of Initial License for Current Owners: 04/26/1905

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership	X	County		
IRS Exemption Code			Corporation		Other		
			"Sub-S" Corp.				
			Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/2000 to 11/30/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Jeremy Maupin
(Title) Administrator

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	153	Skilled (SNF)	153	55,845	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,440	3
4		Intermediate/DD			4
5	34	Sheltered Care (SC)	34	12,410	5
6		ICF/DD 16 or Less			6
7	243	TOTALS	243	88,695	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,864	2,608	4,232	9,704	8
9	SNF/PED					9
10	ICF	31,391	29,464		60,855	10
11	ICF/DD					11
12	SC	1,222	2,812		4,034	12
13	DD 16 OR LESS					13
14	TOTALS	35,477	34,884	4,232	74,593	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.10%

D. How many bed-hold days during this year were paid by Public Aid?
63 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Adult Day Care, Child Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1943

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 153 and days of care provided 4,232

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/2001 Fiscal Year: 11/30/2001

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	692,459	57,444	9,230	759,133		759,133	(3,619)	755,514			1
2	Food Purchase		450,706		450,706		450,706	(55,395)	395,311			2
3	Housekeeping	383,674	34,661		418,335		418,335	(3,322)	415,013			3
4	Laundry	116,045	35,364		151,409		151,409		151,409			4
5	Heat and Other Utilities			336,693	336,693		336,693	(32,271)	304,422			5
6	Maintenance	59,187	16,135	103,700	179,022		179,022	(11,486)	167,536			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,251,365	594,310	449,623	2,295,298		2,295,298	(106,093)	2,189,205			8
	B. Health Care and Programs											
9	Medical Director			1,551	1,551		1,551		1,551			9
10	Nursing and Medical Records	2,629,880	161,353	1,225,210	4,016,443		4,016,443		4,016,443			10
10a	Therapy	24,049	4,446	190,127	218,622		218,622		218,622			10a
11	Activities	221,119	979	2,000	224,098		224,098		224,098			11
12	Social Services	107,679	14		107,693		107,693		107,693			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* **Daycare expenses**	359,327	4,257	6,377	369,961		369,961	(369,961)				15
16	**TOTAL Health Care and Programs**	3,342,054	171,049	1,425,265	4,938,368		4,938,368	(369,961)	4,568,407			16
	C. General Administration											
17	Administrative	83,789		44,446	128,235		128,235	(938)	127,297			17
18	Directors Fees											18
19	Professional Services			70,904	70,904		70,904	(1,544)	69,360			19
20	Dues, Fees, Subscriptions & Promotions			29,926	29,926		29,926	(80)	29,846			20
21	Clerical & General Office Expenses	323,840	17,992	59,021	400,853		400,853	(1,976)	398,877			21
22	Employee Benefits & Payroll Taxes			1,155,239	1,155,239		1,155,239	(51,302)	1,103,937			22
23	Inservice Training & Education			12,046	12,046		12,046		12,046			23
24	Travel and Seminar			13,129	13,129		13,129		13,129			24
25	Other Admin. Staff Transportation			769	769		769	(17)	752			25
26	Insurance-Prop.Liab.Malpractice			113,581	113,581		113,581	(6,511)	107,070			26
27	Other (specify):*											27
28	**TOTAL General Administration**	407,629	17,992	1,499,061	1,924,682		1,924,682	(62,368)	1,862,314			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,001,048	783,351	3,373,949	9,158,348		9,158,348	(538,422)	8,619,926			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Champaign County Nursing Home #0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			278,682	278,682		278,682	(33,425)	245,257			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,192	8,192		8,192		8,192			35
36	Other (specify):*											36
37	**TOTAL Ownership**			286,874	286,874		286,874	(33,425)	253,449			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,932	114,272	5,336	121,540		121,540		121,540			39
40	Barber and Beauty Shops	44,847	2,103		46,950		46,950		46,950			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,323	114,323		114,323		114,323			42
43	Other (specify):* Nonallowable costs			162,097	162,097		162,097	(162,097)				43
44	**TOTAL Special Cost Centers**	46,779	116,375	281,756	444,910		444,910	(162,097)	282,813			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,047,827	899,726	3,942,579	9,890,132		9,890,132	(733,944)	9,156,188			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (369,961)	15	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,541)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(160,297)	43		24
25	Fund Raising, Advertising and Promotional	(259)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached schedule	(201,886)	var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (733,944)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (733,944)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign County Nursing Home

ID# 0001636

Report Period Beginning: 12/01/2000

Ending: 11/30/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Champaign County Nursing Home # 0001636 **Report Period Beginning:** 12/01/2000 **Ending:** 11/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(369,961)	0	0	0	0	0	0	0	0	0	0	(369,961)	15
16	**TOTAL Health Care and Programs**	(369,961)	0	0	0	0	0	0	0	0	0	0	(369,961)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(369,961)	0	0	0	0	0	0	0	0	0	0	(369,961)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Champaign County Nursing Home # 0001636 **Report Period Beginning:** 12/01/2000 **Ending:** 11/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(162,097)	0	0	0	0	0	0	0	0	0	0	(162,097)	43
44	**TOTAL Special Cost Centers**	(162,097)	0	0	0	0	0	0	0	0	0	0	(162,097)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(532,058)	0	0	0	0	0	0	0	0	0	0	(532,058)	45

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Champaign County	100%	N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Treasury Services	$ 5,469	Champaign County	100.00%	$ 5,469	$	1
2	V	17	Auditor's Office Services	38,977	Champaign County	100.00%	38,977		2
3	V	22	IMRF	222,026	Champaign County	100.00%	222,026		3
4	V	22	FICA	373,074	Champaign County	100.00%	373,074		4
5	V	22	Workers Compensation	136,319	Champaign County	100.00%	136,319		5
6	V	22	Unemployment Insurance	41,024	Champaign County	100.00%	41,024		6
7	V	22	Health Insurance	367,524	Champaign County	100.00%	367,524		7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,184,413			$ 1,184,413	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	See attached list	Board of Directors	Administrative	0.00	None		<1%		None	N/A	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 1/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Champaign County
Street Address: 1776 East Washington
City / State / Zip Code: Urbana, IL 61802
Phone Number: (217) 384-3776
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Treasury Services	Direct Cost		All Co. Depts.	$	$	1	$ 5,469	1
2	17	Auditors' Office Services	Direct Cost		All Co. Depts.			1	38,977	2
3	22	IMRF	Direct Cost		All Co. Depts.			1	222,026	3
4	22	FICA	Direct Cost		All Co. Depts.			1	373,074	4
5	22	Workers Compensation	Direct Cost		All Co. Depts.			1	136,319	5
6	22	Unemployment Insurance	Direct Cost		All Co. Depts.			1	41,024	6
7	22	Health Insurance	Direct Cost		All Co. Depts.			1	367,524	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,184,413	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 1/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Champaign County Day Care
Street Address: 1701 E. Main St.
City / State / Zip Code: Urbana, IL 61802
Phone Number: (217) 384-3784
Fax Number: (217) 337-0120

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals	238,525		$ 66,674	$	12,946	$ 3,619	1
2	2	Food	Meals	238,525		450,706		12,946	24,462	2
3	3	Housekeeping	Square feet	63,455		34,661		6,082	3,322	3
4	5	Utilities	Square feet	63,455		336,693		6,082	32,271	4
5	6	Maintenance	Square feet	63,455		119,835		6,082	11,486	5
6										6
7	17	Administrative	Revenue	8,615,114		43,547		185,634	938	7
8	19	Professional Fees	Revenue	8,615,114		71,645		185,634	1,544	8
9	21	Office	Revenue	8,615,114		91,727		185,634	1,976	9
10	22	Employee Benefits	Salaries	5,047,827		1,155,239		359,327	82,235	10
11	25	Staff Transportation	Revenue	8,615,114		769		185,634	17	11
12	26	Insurance - Auto	Direct allocation	1		4,064		1	4,064	12
13	26	Insurance - Other	Revenue	8,615,114		113,581		185,634	2,447	13
14	30	Depreciation - Auto	Direct allocation	1		7,426		1	7,426	14
15	30	Depreciation - Other	Square feet	63,455		271,256		6,082	25,999	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,767,823	$		$ 201,806	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2				N/A								2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

Not applicable

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign County Nursing Hom COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0001636

CONTACT PERSON REGARDING THIS REPORT Amanda Knight, Comptroller

TELEPHONE (217) 384-3784 FAX #: (217) 337-0120

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Facility does not pay real estate taxes		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 101,931 B. General Construction Type: Exterior Brick Frame Reinforced concrete Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Adult Day Care & Child DayCare - 6,082 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care	1,829,520	1865	$ 2,100	1
2					2
3	TOTALS	1,829,520		$ 2,100	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	153		1973	1973	$ 2,085,435	$ 52,136	40	$ 52,136	$	$ 1,472,839	4
5	56		1910	1971	734,760		25			734,760	5
6	34			1971	207,240		25			207,240	6
7			1989	1989	34,891	872	40	872		10,908	7
8											8
	Improvement Type**										
9	Building improvements			1972	10,300		25			10,300	9
10	Building improvements			1973	146,645		25			146,645	10
11	Building improvements			1974	288,473		25			288,473	11
12	Building improvements			1974	18,482	462	40	462		12,644	12
13	Building improvements			1975	25,353		25			25,353	13
14	Building improvements			1976	6,342		15			6,342	14
15	Building improvements			1977	3,399		15			3,399	15
16	Building improvements			1977	8,548	342	25	342		8,377	16
17	Building improvements			1980	2,469		15			2,469	17
18	Building improvements			1981	36,818		15			36,818	18
19	Building improvements			1982	57,322		15			57,322	19
20	Building improvements			1983	31,084		10			31,084	20
21	Building improvements			1984	223,985	9,344	24	9,344		163,524	21
22	Building improvements			1985	57,958	2,953	20	2,953		47,267	22
23	Building improvements			1986	254,092	10,164	25	10,164		157,537	23
24	Building improvements			1987	81,739	4,153	20	4,153		60,227	24
25	Building improvements			1988	345,563	13,823	25	13,823		186,604	25
26	Building improvements			1989	64,947	2,598	25	2,598		32,474	26
27	Building improvements			1990	251,292	10,052	25	10,052		115,594	27
28	Building improvements			1991	163,384	6,535	25	6,535		68,621	28
29	Building improvements			1992	138,101	5,524	25	5,524		52,479	29
30	Building improvements			1993	62,716	2,509	25	2,509		21,323	30
31	Building improvements			1994	360,106	14,404	25	14,404		108,032	31
32	Building improvements			1995	28,420	1,138	25	1,138		7,394	32
33	Building improvements			1996	21,058	842	15	842		4,633	33
34	Parking lot			1977	25,035					24,035	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Tree care	1981	$ 465	$	15	$	$	$ 465	37
38	Landscaping additions	1982	1,870		10			1,870	38
39	Landscaping additions	1983	5,250		5			5,250	39
40	Landscaping additions	1987	3,491		5			3,491	40
41	Landscaping additions	1988	1,971	131	15	131		1,774	41
42	Landscaping additions	1989	6,125	408	15	408		5,105	42
43	Landscaping additions	1990	3,596	240	15	240		2,757	43
44	Landscaping additions	1991	11,069	738	15	738		7,754	44
45	Landscaping additions	1992	2,969	198	15	198		1,881	45
46	Parking lot expansion	1996	67,139	4,602	15	4,602		25,621	46
47	Smoke detectors	1997	4,524	905	5	905		4,072	47
48	Redecorating-ADC	1997	1,459	292	5	292		1,313	48
49	Sprinkler backflow preventor	1997	6,230	623	10	623		2,804	49
50	Fire door - Activity office	1997	626	63	10	63		282	50
51	Wall-Dietary	1997	705	70	10	70		317	51
52	Mini blinds - Dining area	1997	1,045	209	5	209		941	52
53	Tuckpointing - Administration bldg	1997	11,400	456	25	456		2,052	53
54	Flooring improvements	1997	3,306	661	5	661		2,975	54
55	Asbestos removal	1998	45,350	1,814	25	1,814		6,339	55
56	Project planning - ARD expansion	1998	35,513	7,103	5	7,103		24,859	56
57	Air conditioning - Chiller replacement	1998	193,621	9,681	20	9,681		33,884	57
58	Hot water treatment system	1998	1,422	284	5	284		995	58
59	Pipe insulation	1998	3,201	160	20	160		560	59
60	Door sensor beam	1998	567	113	5	113		397	60
61	Vanity replacement (wing)	1998	16,236	812	20	812		2,841	61
62	Shower tile replacement (B wing)	1998	1,064	71	15	71		248	62
63	Heat exchanger replacement	1998	4,417	442	10	442		1,546	63
64	Pipe insulation	1998	97	5	20	5		17	64
65	Asbestos removal	1998	4,792	192	25	192		671	65
66	Cable for computer	1999	7,350	490	15	490		1,225	66
67	Chiller replacement electrical	1999	3,465	173	20	173		433	67
68	Door alarm on B wing	1999	1,808	181	10	181		452	68
69	Carpet - 3 offices	1999	814	163	5	163		407	69
70	TOTAL (lines 4 thru 69)		$ 6,228,914	$ 169,131		$ 169,131	$	$ 4,250,315	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,228,914	$ 169,131		$ 169,131	$	$ 4,250,315	1
2	Door alarm hook-up	1999	50	5	10	5		13	2
3	Stainless steel wall coverings	1999	1,382	69	20	69		173	3
4	Flipper cabinet w/ hanging tracks	1999	297	20	15	20		50	4
5	Flipper cabinet w/ hanging tracks	1999	1,216	81	15	81		203	5
6	Door magnets (door alarms)	1999	144	14	10	14		36	6
7	Ceramic flooring	1999	3,192	160	20	160		399	7
8	Carpet in 2 offices	1999	918	184	5	184		459	8
9	Hollow metal door	1999	788	39	20	39		98	9
10	Annunciator	1999	400	40	10	40		100	10
11	Unit heater for bus ban	1999	569	38	15	38		95	11
12	Privacy panels & hardware	1999	518	104	5	104		259	12
13	A-wing nursing station	1999	4,333	289	15	289		722	13
14	Hook-up call system	1999	734	49	15	49		122	14
15	Computer cable	2000	810	54	15	54		95	15
16	Stainless folding for shower rooms	2000	578	58	15	58		101	16
17	Vinyl flooring	2000	960	192	10	192		208	17
18	Concrete fountain	2000	1,000	40	25	40		60	18
19	Remodel Annex corner	2001	443	22	5	22		22	19
20	Conversion of Activity room to Dining	2001	2,079	104	5	104		104	20
21	Major repair-Walk-in refrigerator	2001	526	9	5	9		9	21
22	Vinyl flooring	2001	898	7	5	7		7	22
23	Stairway treads	2001	1,495	12	5	12		12	23
24	Carpet - Canopy walkway	2001	980	16	5	16		16	24
25	Tree removal	2001	975	56	10	56		56	25
26	Fire alarm update	2001	1,273	106	10	106		106	26
27	Dishwasher fan	2001	4,285	286	10	286		286	27
28	ADC alarm	2001	566	38	10	38		38	28
29	Activity room phone system	2001	110	4	10	4		4	29
30	Wing door alarm	2001	886	44	10	44		44	30
31	Door alarm system	2001	857	36	10	36		36	31
32									32
33	LESS: Assets allocated to Day Care			(33,425)		(33,425)			33
34	TOTAL (lines 1 thru 33)		$ 6,262,176	$ 137,882		$ 137,882	$	$ 4,254,248	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,420,743	$ 93,345	$ 93,345	$	5-15	$ 1,108,649	71
72	Current Year Purchases	88,210	6,604	6,604		7	6,604	72
73	Fully Depreciated Assets	391,350					391,350	73
74								74
75	TOTALS	$ 1,900,303	$ 99,949	$ 99,949	$		$ 1,506,603	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident use	90 Chevrolet Wagon	1996	$ 3,621	$ 362	$ 362	$	10	$ 1,992	76
77	Resident use	96 Ford Bus	1996	36,532	3,653	3,653		10	20,094	77
78	Resident use	98 Dodge Van	1998	33,746	3,375	3,375		10	11,811	78
79	Resident use	Lift for van	2001	537	36	36		5	36	79
80	TOTALS			$ 74,436	$ 7,426	$ 7,426	$		$ 33,933	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,239,015	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 245,257	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 245,257	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,794,784	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88			N/A		88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93		N/A	93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 8,192 Description: Trash compactor - 3,216; Pager - 191; Medical equipment = 4,785
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ n/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES
[X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(1, 2, 3)	hrs	$ 24,049	5,521	$ 69,017	$ 1,532	5,521	$ 94,598	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,015	12,682		1,015	12,682	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2, 3)	hrs		7,166	89,570	2,914	7,166	92,484	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				114,088		114,088	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39(1, 2, 3)	70	1,932	426	5,336	184	496	7,452	12
13	Other (specify):									13
14	TOTAL			$ 25,981	14,128	$ 176,605	$ 118,718	14,198	$ 321,304	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 513,441	$ 513,441	1
2	Cash-Patient Deposits	32,065	32,065	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 67,057)	1,272,833	1,272,833	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	954,089	954,089	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	93,875	93,875	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest receivable	3,595	3,595	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,869,898	$ 2,869,898	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,100	2,100	13
14	Buildings, at Historical Cost	6,129,120	6,129,120	14
15	Leasehold Improvements, at Historical Cost	130,956	130,956	15
16	Equipment, at Historical Cost	1,974,739	1,974,739	16
17	Accumulated Depreciation (book methods)	(5,794,784)	(5,794,784)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,442,131	$ 2,442,131	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,312,029	$ 5,312,029	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 474,061	$ 474,061	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,065	32,065	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	388,882	388,882	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to other funds	169,549	169,549	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,064,557	$ 1,064,557	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,064,557	$ 1,064,557	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,247,472	$ 4,247,472	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,312,029	$ 5,312,029	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,000,363	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,000,363	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(752,891)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (752,891)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,247,472	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,429,480	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,429,480	3
	B. Ancillary Revenue		
4	Day Care	185,634	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 185,634	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	178,929	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	42,660	13
14	Non-Patient Meals	19,808	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	134,206	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 375,603	23
	D. Non-Operating Revenue		
24	Contributions	8,203	24
25	Interest and Other Investment Income***	83,242	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 91,445	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See attached schedule	55,079	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 55,079	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,137,241	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,295,298	31
32	Health Care	4,938,368	32
33	General Administration	1,924,682	33
	B. Capital Expense		
34	Ownership	286,874	34
	C. Ancillary Expense		
35	Special Cost Centers	330,587	35
36	Provider Participation Fee	114,323	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,890,132	40
41	**Income before Income Taxes (line 30 minus line 40)****	(752,891)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (752,891)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility files as part of the county return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,066	2,106	$ 51,988	$ 24.69	1
2	Assistant Director of Nursing	2,080	2,238	49,796	22.25	2
3	Registered Nurses	17,550	19,902	371,987	18.69	3
4	Licensed Practical Nurses	25,015	28,438	410,335	14.43	4
5	Nurse Aides & Orderlies	114,169	130,774	1,295,381	9.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,866	2,026	24,049	11.87	7
8	Rehab/Therapy Aides	3,619	4,181	46,590	11.14	8
9	Activity Director	2,102	2,236	41,421	18.52	9
10	Activity Assistants	13,069	13,362	137,747	10.31	10
11	Social Service Workers	6,106	6,435	107,679	16.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	73,998	80,691	692,459	8.58	15
16	Dishwashers					16
17	Maintenance Workers	4,479	5,007	59,187	11.82	17
18	Housekeepers	36,307	40,559	383,674	9.46	18
19	Laundry	11,808	13,137	116,045	8.83	19
20	Administrator	2,042	2,046	83,789	40.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,562	17,415	323,840	18.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,829	2,192	22,710	10.36	31
32	Other Health Ca See Attached	21,480	23,427	424,976	18.14	32
33	Other(specify) See Attached	32,612	35,212	404,174	11.48	33
34	TOTAL (lines 1 - 33)	388,759	431,384	$ 5,047,827 *	$ 11.70	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	247	$ 9,230	1(3)	35
36	Medical Director	Monthly	1,551	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,300	10(3)	39
40	Physical Therapy Consultant	204	10,180	10A(3)	40
41	Occupational Therapy Consultant	160	7,988	10A(3)	41
42	Respiratory Therapy Consultant	14	690	10A(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	624	$ 32,939		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,116	$ 50,225	10(3)	50
51	Licensed Practical Nurses	4,456	147,042	10(3)	51
52	Nurse Aides	34,119	887,104	10(3)	52
53	TOTAL (lines 50 - 52)	39,691	$ 1,084,371		53

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Hodson	Interim Admin.	0%	$ 3,985
Jeremy Maupin	Administrator	0%	79,804
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,789

B. Administrative - Other

Description	Amount
Champaign County - Treasurer Services	$ 5,469
Champaign County - Audit & Accounting Services	38,977
TOTAL (agree to Schedule V, line 17, col. 3)	$ 44,446
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Meyer, Capel et.al.	Legal	$ 10,792
Champaign Co. Recorder	Mortgage release	18
American Expr. Tax & Bus. Svcs.	Accounting	13,800
FR&R Consulting	Accounting	1,861
Olive LLP	Accounting	11,268
Medline Industries	Billing fees	12,160
Arends & Sons, Inc	Internet consultation	147
Ban-Koe Systems, Inc.	Internet consultation	250
Champaign Co. Treasurer	Computer support	910
Senior Living Services	Software support	6,495
Egix/Advance Net	Internet services/support	195
P.K. Demars, Inc	Architectural consulting	13,008
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 70,904

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 136,319
Unemployment Compensation Insurance	41,024
FICA Taxes	373,074
Employee Health Insurance	367,524
Employee Meals	30,933
Illinois Municipal Retirement Fund (IMRF)*	222,026
Employee Development & Morale	6,663
Employee Physicals & Labs	6,109
Employee Relocation Expenses	2,500
Less: Amount allocated to Day Care	(82,235)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,103,937

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,714
Health Care Worker Background Check	
(Indicate # of checks performed 60)	741
Life Services Network of Illinois dues	4,442
Illinois Health Care Assn. Dues	7,948
Other dues & licenses	1,030
Books, periodicals & subscriptions	1,051
Less: Public Relations Expense	(80)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,846

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached detail	13,129
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,129

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7						N/A							
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Y es**
If YES, give association name and amount. **LSNI-4,442; IHCA-7,948**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.0 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **82,905** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **114,323**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **Yes-see page 8A** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **30,933** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Bray, Drake, Guthrie & Richardson** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Champaign County Nursing Home
Facility #: 0001613
12/01/2000 - 11/30/2001 **Supplementary Information**

Page 3: Line 15, Col. 1 - Other Wages

Adult Day Care Wages	225,256
Child Day Care Wages	134,071
Total Line 15(1)	359,327

Page 3: Line 15, Col. 2 - Other Supplies

Adult Day Care Supplies	2,772
Child Day Care Supplies	1,485
Total Line 15(2)	4,257

Page 3: Line 15, Col. 3 - Other

Adult Day Care Other	6,368
Child Day Care Other	9
Total Line 15(3)	6,377

Page 5: Line 29 - Other non-allowable expenses	Amount	Ref
Kiwanis dues	(80)	20
Day care costs:		
Dietary	(3,619)	1
Food	(24,462)	2
Housekeeping	(3,322)	3
Utilities	(32,271)	5
Maintenance	(11,486)	6
Administrative	(938)	17
Professional fees	(1,544)	19
Office expense	(1,976)	21
Employee benefits	(82,235)	22
Staff transportation	(17)	25
Insurance	(6,511)	26
Depreciation	(33,425)	30
Total Line 29	(201,886)	

Page 19: Line 27 - Other revenue

Outside food service	289
Resident transportation charges	4,920
Lage charges & NSF check fees	42,276
Insurance reimbursement	6,800
Other miscellaneous revenue	794
Total Line 27	55,079

Page 20: Line 32 - Other Healthcare	Hours Worked	Hours Paid	Wages	Ave. Rate
Unit Secretary	4,571	4,602	35,951	7.81
Nursing Service Coordinator	9,619	10,721	221,056	20.62
Care Plan Coordinator	1,835	2,088	48,254	23.11
Dental Hygenist	1,497	1,601	33,310	20.81
ARD Unit Coordinator	1,878	2,327	41,951	18.03
Restorative Care Coordinator	2,080	2,088	44,454	21.29
Tolal Line 32	21,480	23,427	424,976	18.14

Page 20: Line 33 - Other	Hours Worked	Hours Paid	Wages	Ave. Rate
Beauty Shop	4,066	4,359	44,847	10.29
Adult Day Care	17,041	18,060	225,256	12.47
Child Day Care	11,505	12,793	134,071	10.48
Total Line 33	32,612	35,212	404,174	11.48

Page 21: Schedule C - Professional services

Total Professional services	70,904
Allocated to Day Care and eliminated	(1,544)
Total Sch. V Line 19(3)	69,360

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Champaign County Nurs** **02:19 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-733,944	equal to	-733,944	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	245,257	equal to	245,257	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	8,192	equal to	8,192	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	25,981	equal to	1,932	24,049	FAILED	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	218,622	equal to	218,622	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	118,718	equal to	118,718	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	2,295,298	equal to	2,295,298	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,938,368	equal to	4,938,368	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,924,682	equal to	1,924,682	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	286,874	equal to	286,874	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	330,587	equal to	330,587	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	114,323	equal to	114,323	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,202,197	equal to	2,629,880	-427,683	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	24,049	equal to	1,932	22,117	FAILED	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	179,168	equal to	221,119	-41,951	FAILED	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	107,679	equal to	107,679	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	692,459	equal to	692,459	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	59,187	equal to	59,187	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	383,674	equal to	383,674	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	116,045	equal to	116,045	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	83,789	equal to	83,789	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	323,840	equal to	323,840	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	5,047,827	equal to	5,047,827	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	9,230	< or = to	9,230	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	1,551	< or = to	1,551	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,087,671	< or = to	1,225,210	-137,539	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	2,000	-2,000	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	83,789	equal to	83,789	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	44,446	equal to	44,446	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	70,904	equal to	70,904	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	1,103,937	equal to	1,103,937	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	29,846	equal to	29,846	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	13,129	equal to	13,129	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	114,323	equal to	114,323	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	30,933	< or = to	-51,302	82,235	FAILED	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	30,933	equal to	30,933	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	4,232	equal to	4,232	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	2,100	equal to	2,100	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,262,176	equal to	6,260,076	2,100	FAILED	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,974,739	equal to	1,974,739	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	5,794,784	equal to	5,794,784	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	4,247,472	equal to	4,247,472	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-752,891	equal to	-752,891	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	5,312,029	equal to	5,312,029	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1